PAGE	03/14
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(X2) MULTIPLE CONSTRUC	TION	V

PRIMIED:	02/02/2011
FORM A	APPROVED
OMB NO.	0938-0391
, , , , , , , , , , , , , , , , , , , 	

(X3) DATE SURVEY
COMPLETED

C 01/27/2011

155133

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

B. WING

A. BUILDING

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

COLUMBUS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY STREET COLUMBUS, IN 47201

ł					
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Ì					

F 000 INITIAL COMMENTS

This visit was for the investigation of complaint IN00085122 and complaint IN00085432.

Complaint IN00085122 substantiated, federal/state deficiencies related to the allegations are cited at F282, F431 and F514.

Complaint IN00085432 unsubstantiated due to lack of evidence.

Survey dates: January 24, 25, 26 and 27, 2011

Facility number: 000058 Provider number: 155133 AIM number: 100283340

Survey team:

Penny Marlatt, RN

Census bed type: SNF/NF: 180 Total: 180

Census payor type: Medicare: 27

Medicaid: 126 Other: 27 Total: 180

Sample: 5

These deficiencies also reflect state findings in

accordance with 410 IAC 16.2.

Quality review completed 1-30-11 Cathy Emswiller RN

483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282

PERSONS/PER CARE PLAN SS=D

F 000 This Plan of Correction is the center's credible allegation of compliance.

> Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

- Corrective actions: Resident D will receive her medication as ordered by her physician. The nurse was
- 2. The Unit Manager or designee will check the Narcotic sheets, using the Morning checklist. Each resident receiving a narcotic will have their narcotic count sheet checked against the MAR.
- 3. The DNS or designee will assure controlled substances are counted at shift change or when keys are rendered; on the controlled drugs count sheet. The DNS or designee will assure that results of the count on controlled substances are documented, on the count sheet. The DNS or designee will inservice the staff that when a medication is administered, the physicians order is verified. The label on the medication will be checked when taking the medication from the drawer, when pouring or popping the medication and when returning the medication to the cart. The DNS or designee will observe a medication pass on nurses that pass medication; on the medication

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

administration form.

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

F 282

Executive Dir.

Facility ID: 000058

If continuation sheet Page 1 of 12

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	/ULTIF	PLE CONSTRUCTION		(X3) DATE S COMPLI	
,		155133	B. W	NG		<u> </u>	1	C 7/2011
-	PROVIDER OR SUPPLIER BUS HEALTH AND R			21	EET ADDRESS, CITY, STA' 00 MIDWAY STREET OLUMBUS, IN 47201	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLA (EACH CORRECTIV CROSS-REFERENCE DEFI	E ACTION SHOW	JLD BE	(X5) COMPLETION DATE
F 282	The services provi	age 1 ded or arranged by the facility by qualified persons in ach resident's written plan of	F	282	4. The DNS or of narcotic cound basis; Audits the Performan Committee x substantial co. 5. Completion D	t sheet on a w will be presence Improvem 3 months or u mpliance.	eekly ated to ent	
	by: Based on record re failed to administer antianxiety medica physician on 5 occ 1 of 4 residents rev	NT is not met as evidenced eview and interview, the facility the correct dosage of tion that was ordered by the asions in a 6 day time period in viewed for pain/comfort in a esidents. (Resident D)						
	1-26-11 at 9:15 a.n were not limited to depression, osteop congestive heart fa	al record was reviewed on n. Her diagnoses included, but anxiety, senile dementia, orosis, osteoarthritis, ilure (heart problems), blood pressure), and anorexia uate nutrition).						
	physician indicated antianxiety medical morning and 0.5 m review of the control account of each pill time period 11-10-1 separate doses adr 11-10-10, 11-13-10 received ativan 0.5 11-15-10, the log in 2 doses of ativan 0.	of care ordered by her she was to receive ativan (an ion) 1.0 milligram (mg) each g each evening by mouth. In olled substance log (a written used) indicated during the 0 and 11-15-10, there were 5 ministered incorrectly. On , and 11-14-10, this resident mg in the moming. On dicated the resident received 5 mg, a total of 1.0 mg for the controlled substance log						

PRINTED: 02/02/2011 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES), 0938-039
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE : COMPL	SURVEY
		155133	B. WING	· · · · · · · · · · · · · · · · · · ·	— na/	C 27/2011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	21	EET ADDRESS, CITY, STATE, Z 00 MIDWAY STREET DLUMBUS, IN 47201		L172011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	indicated no dosage morning of 11-15-1 In interview with the 1-27-11 at 1:15 p.m nurse's who had give (on 11-13-10 and 1 float nurse. In review of the faci Medication Administrator on 1-2 revision date of 10-1 to verify physician indicated to check the sparate times, whe the shelf or drawer,	e of ativan given on the	F 282			
F 431 SS=D	drawer. This federal tag rela IN00085122. 3.1-35(g)(2) 483.60(b), (d), (e) DI LABEL/STORE DRU The facility must em a licensed pharmacis of records of receipt controlled drugs in staccurate reconciliation records are in order as	tes to complaint number RUG RECORDS, JGS & BIOLOGICALS ploy or obtain the services of st who establishes a system	F 431			
		s used in the facility must be with currently accepted				

professional principles, and include the

COLUMBUSHEALTHREHAB

PAGE 06/14

DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
PENTERS FOR	MEDICARE	S. MEDICAID	SED//ICES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE	LETED
		155133	a. Wil	NG_	·	01/	C 27/2011
COLUM	T	HABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 100 MIDWAY STREET COLUMBUS, IN 47201		MA 9 F Con No. 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431	appropriate accessor instructions, and the applicable. In accordance with facility must store at locked compartment controls, and permit have access to the lateral to the facility must propermanently affixed controlled drugs listed controlled drugs listed Comprehensive Dru Control Act of 1976 abuse, except when package drug distribution quantity stored is mit be readily detected.	expiration date when State and Federal laws, the I drugs and biologicals in the sunder proper temperature only authorized personnel to keys. Vide separately locked, compartments for storage of the in Schedule II of the graph Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can	F	131	This Plan of Correction is the center's created allegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. It correction is prepared and/or executed solit is required by the provisions of federal at a correction is prepared and/or executed solit is required by the provisions of federal a corrective actions: Reside longer resides in the facilit nurse involved has been concluded against the MAR. 2. Residents receiving a narrow their narcotic count is checked against the MAR. 3. The DNS or designee will the staff is educated on consubstances count sheets. The includes Date of receipt, It name, Name and strength medication, Prescription mand the Amount of medication received. The DNS will entitle Pharmacy or designee.	of correction It by the conclusions The plan of fely because and state law. ent A no ty. Any ounseled, cotic will sheet assure introlled this Resident's of umber stion usure that	
	by: Based on record revifalled to ensure proportion of a controlled substated document the adminisubstance for 1 of 4 ipain/comfort in a total (Resident A) Findings include: Resident A's clinical in 1-25-11 at 10:15 a.m. but were not limited to buttocks, chronic renifalled to buttocks, chronic renifalled to the control of the control	ew and interview, the facility er documentation of receipt ance and failed to properly stration of a controlled residents reviewed for I sample of 5 residents. record was reviewed on Her diagnoses included, o Stage 2 pressure area on al failure (kidney failure), ly, history of perforated			inservice the staff on the production of controller substances. 4. The DNS or designee will weekly reconciliations of receipt, disposition and investigated for all controlled medication DNS or designee will main controlled medication receipt/record/disposition is ring binder with tabs for earnouth. Audits will be presented the Performance Improvem Committee x 3 months or usubstantial compliance. 5. Date of Completion 2-26-1	do records or rentory ons. The ratain the in a 3-rach ented to ment until in	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
,		165133	B. WI	NG_		1	C 7/2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE		1 3112	0112112011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	. (X5) COMPLETION DATE
F 431	viscus and of sigmo repair; respiratory for blood pressure), bil (infection in both lur	oid colon (4/10) with surgical ailure, hypertension (high ateral pleural effusion ngs) and chronic anemia.	F	4 31			
	indicated multiple medications for pair a.m., a physician te orders from the atte (a continuous, long sulfate) 30 milligram and an order for MS morphine sulfate) 3 for breakthrough pawas documented or Administration Reco	ord (MAR) on the same date times listed as 1:00 a.m. and 6 Contin 30 mg to be given MSIR 30 mg to be given every for pain. Both of these	· .				
	given on 8-2-10 at 1 and 1:00 p.m. and o MAR and a Pain Mo the MSIR was admir without a time listed	the MS Contin 30 mg was :00 p.m., 8-3-10 at 1:00 a.m. in 8-4-10 at 1:00 a.m. The initoring Flowsheet indicated histered on 8-2-10 one time on 8-3-10 at 2:00 a.m., at m. and at 2:30 p.m.; and on					
	the MS Contin or the Director of Nursing (p.m., she provided a indicated 2 pills each she indicated as the	cotic log was not found for MSIR. In interview with the DON) on 1-25-11 at 4:30 copy of a fax sheet which were received from what "other pharmacy." The faxed 2 pills each of MS Contin 30					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155133	B. WING			·		C 7/2011
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		210	ET ADDRESS, CITY, STATE, ZIF O MIDWAY STREET LUMBUS, IN 47201	CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHO THE APPR	VLD BE	(X5) COMPLETION DATE
F 431	mg and MSIR 30 m with no time listed, persons who delive persons who received indicated this pharm medication to get the next regular deliver. She indicated, "Whe we don't have a spea sign out sheet who pharmacy delivery." In interview with the p.m., she indicated pharmacy which roothe facility. She indicated pharmacy which roothe facility. She indicated pharmacy which roothe facility is she indicated, but that she sulfate, but that she	ng were delivered on 8-2-10 nor names nor signatures of ared the medication or of ared the medications. She macy will send just enough arough until the facility gets the area of their regular pharmacy, en we get such small doses, ecific sign out sheet. We have sen we get it from the regular	F 4	31				
}	substance was adn destruction log [whi of medication rema facility or returned to the medication was order or the resident facility.] In interview with the p.m., she provided a Manifest (Schedule 8-2-10 at 4:40 p.m., 30 tablets each of M ([equivalent to MS C Sulfate IR 30 mg [example of the DON indicated narcotic log or destrance of the medication.	ninistered and by whom] nor a ch would indicate the quantity ined and was destroyed by the othe pharmacy company if discontinued by a physician at was discharged/left the DON on 1-26-11 at 2:12 a copy entitled "Shipping CII-CV)", dated and signed indicating the facility received forphine Sulfate ER 30 mg Contin 30 mg] and Morphine equivalent to MSIR 30 mg], she was unable to locate a ruction log for either						
	On 1-26-11 at 11:55	a.m., the DON provided a						-

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION	(X3) DATE : COMPL	
		155133	B. WIN	IG		01/	C 27/2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 100 MIDWAY STREET COLUMBUS, IN 47201	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	copy of the facility's Medications," with a This policy indicate maintain a system of disposition, and recomedications. This is limited to: (a.). recomedications with sureconciliation (i.e., strength of the med received, and the nof usage and disposimedications with sureconciliation (i.e., trecord (MAR), proof inventory sheets), in	policy entitled, "Controlled a revision date of 1-15-10. d the DON is responsible "to for the receipt, usage, onciliation of controlled system includes, but is not and of receipt of all controlled afficient detail to allow specifying the name and ication, quantity and date esident's name.); (b.) records sition of all controlled afficient detail to allow specifying the name and ication, quantity and date esident's name.); (b.) records sition of all controlled afficient detail to allow the medication administration for use sheets, or declining icluding destruction, wastage, acy/manufacturer, or disposal	F4	131			
F 514 SS=D	3.1-25(e)(2) 3.1-25(e)(3) 3.1-25(s)(1) 3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8) 483.75(I)(1) RES RECORDS-COMPLI	ETE/ACCURATE/ACCESSIB	F 51	4			
		ntain clinical records on each ce with accepted professional			•		·

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	155133		B, WIN	1G		01/27/2011	
NAME OF PROVIDER OR SUPPLIER COLUMBUS HEALTH AND REHABILITATION CENTER				21	EET ADDRESS, CITY, STATE, ZIP CODE 100 MIDWAY STREET OLUMBUS, IN 47201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	standards and pracaccurately docume systematically orga. The clinical record information to identresident's assessm services provided; preadmission scree and progress notes. This REQUIREMED by: 1. The facility failed tracking mechanism substances in 1 of pain/comfort in a to (Resident A) 2. The facility failed controlled substance documented. (Resident A) 1. Resident A's clin 1-25-11 at 10:15 a. In but were not limited buttocks, chronic redialysis 3 times were viscus and of sigmore pair; respiratory fablood pressure), bila (infection in both lun Review of the physicindicated multiple medications for pain	ctices that are complete; inted; readily accessible; and sinized. must contain sufficient tify the resident; a record of the sents; the plan of care and the results of any ening conducted by the State; in the next as evidenced if to ensure an accurate in for use of controlled it residents reviewed for tall sample of 5 residents. It to ensure accuracy of the es provided were properly	F5	514	This Plan of Correction is the center's crallegation of compliance. Preparation and/or execution of this plandoes not constitute admission or agreem provider of the truth of the facts alleged set forth in the statement of deficiencies. correction is prepared and/or executed sit is required by the provisions of federal longer resides in the facinurse involved has been 2. Each resident that is recently and have their recount sheet checked again MAR. 3. The DNS will ensure the Pharmacy or designee will assure the staff on the proper documentation of controlled substances. The DNS or will assure the staff is education for medication, Pharmacy and the Amount medication received. The ensure that the Pharmacy designee will inservice the proper documentation controlled substances. The proper documentation received. The ensure that the Pharmacy designee will inservice the proper documentation controlled substances. The designee will observe a medication. The DNS or will assure that the staff is education. The DNS or will assure that the staff in the proper documentation controlled substances.	n of correction ent by the or conclusions. The plan of total because and state law. Ident D will so ordered ent A no lity. Any counseled. Eving a narcotic ent the ent the ent the ent the ent the ent the ent of the count Date of the DNS will be or the staff on the DNS or needication is designee designee.	
	orders from the atte	nding physician for MS Contin acting version of morphine	٠.		that when a medication is administered, the physici		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C 01/27/2011		
		B. WING	9			
NAME OF PROVIDER OR SUPPLIER COLUMBUS HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODI 2100 MIDWAY STREET COLUMBUS, IN 47201		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION . DATE
	sulfate) 30 milligram and an order for MS morphine sulfate) 30 for breakthrough pa was documented or Administration Reco with administration to 1:00 p.m. for the MS twice daily and the M4 hours as needed for medications are con The MAR indicated to given on 8-2-10 at 1: and 1:00 p.m. and of MAR and a Pain Mothe MSIR was admir without a time listed;	ns (mg) twice daily by mouth IR (short-acting version of mg every 4 hours as need in. This same information the Medication and (MAR) on the same date imes listed as 1:00 a.m. and Contin 30 mg to be given every or pain. Both of these trolled substances. The MS Contin 30 mg was 00 p.m., 8-3-10 at 1:00 a.m. and 8-4-10 at 1:00 a.m. The nitoring Flowsheet indicated istered on 8-2-10 one time on 8-3-10 at 2:30 p.m.; and on	F 51	is verified, the label on the medication will be checked taking the medication from drawer, when pouring or the medication and when the medication to the cart. 4. The DNS or designee will weekly reconciliations of receipt, disposition and in for all controlled medications binder will be maintated tabs for each month. The leasing weekly and the nancount sheet weekly. Audit presented to the Performant Improvement Committee a months or until in substant compliance. 5. Date of Completion 2-26-1	ed when in the copping returning do records or ventory ons; a 3- ined with ONS or cotic s will be ice (3 ial	
i i i i i i i i i i i i i i i i i i i	the MS Contin or the Director of Nursing (I p.m., she provided a indicated 2 pills each she indicated as the 'document indicated 2 mg and MSIR 30 mg with no time listed, no persons who delivere persons who received indicated this pharma medication to get throwext regular delivery fishe indicated, "When we don't have a speci	cotic log was not found for MSIR. In interview with the DON) on 1-25-11 at 4:30 copy of a fax sheet which were received from what other pharmacy." The faxed pills each of MS Contin 30 were delivered on 8-2-10 or names nor signatures of the medication or of the medications. She cy will send just enough up until the facility gets the rom their regular pharmacy, we get such small doses, fic sign out sheet. We have we get it from the regular				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		Į.	IULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	155133		B. WI			C 01/27/2011	
NAME OF PROVIDER OR SUPPLIER COLUMBUS HEALTH AND REHABILITATION CENTER				210	ET ADDRESS, CITY, STATE, ZIP CODE 00 MIDWAY STREET DLUMBUS, IN 47201	U372	27/2011
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 514	p.m., she indicated pharmacy which routhe facility. She ind her they had sent be sulfate, but that she log [which indicates substance was admidestruction log [which indicates of medication remains facility or returned to the medication was	DON on 1-26-11 at 1:25 she had spoken to the utinely provides medication to icated the pharmacy had told oth forms of the morphine could not locate the narcotic	F	514			
	p.m., she provided a Manifest (Schedule 8-2-10 at 4:40 p.m., 30 tablets each of M ([equivalent to MS C Sulfate IR 30 mg [each	DON on 1-26-11 at 2:12 a copy entitled "Shipping CII-CV)", dated and signed indicating the facility received orphine Sulfate ER 30 mg contin 30 mg] and Morphine quivalent to MSIR 30 mg] she was unable to locate a uction log for either					
	copy of the facility's periodications," with a This policy indicated maintain a system for disposition, and recommedications. This symmetrications with suffreconciliation (i.e., spectrength of the medications with suffreconciliation (i.e., spectrength of the medications.)	nciliation of controlled rstem includes, but is not all controlled					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		155133	B. WI	4G_		04/	C 27/2011	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	.1	2.	LEET ADDRESS, CITY, STATE, ZIP CODE 100 MIDWAY STREET OLUMBUS, IN 47201		2772011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 514	of usage and dispose medications with su reconciliation (i.e., t record (MAR), proo- inventory sheets), ir	sition of all controlled fficient detail to allow he medication administration f-of-use sheets, or declining notuding destruction, wastage, acy/manufacturer, or disposal	F	514				
·	1-26-11 at 9:15 a.m were not limited to a depression, osteopo congestive heart fail	lure (heart problems), blood pressure), and anorexia						
	physician indicated santianxiety medication morning and 0.5 mg review of the control account of each pill time period 11-10-10 separate doses adm 11-10-10, 11-13-10, received ativan 0.5 mm 11-15-10, the log ind 2 doses of ativan 0.5 evening dose. The control of	care ordered by her she was to receive ativan (an on) 1.0 milligram (mg) each each evening by mouth. In led substance log (a written used) indicated during the 0 and 11-15-10, there were 5 inistered incorrectly. On and 11-14-10, this resident ng in the morning. On licated the resident received org, a total of 1.0 mg for the controlled substance log of ativan given on the						
	1-27-11 at 1:15 p.m., nurse's who had give	Director of Nursing on she identified one of the 2 of the incorrect dosages 14-10 morning doses) as a		-				
						ļ	.	

MAGE	14/14
JTED: 0	2/02/2011

		HAND HUMAN SERVICES E & MEDICAID SERVICES		•	•		FORM	1 APPROVED 0. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL	ULTIPLE CONSTR	(X3) DATE SURVEY COMPLETED						
155133			B. WIN	lG		C 01/27/2011				
NAME OF PROVIDER OR SUPPLIER COLUMBUS HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY STREET COLUMBUS, IN 47201						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EAC	CH CORRECTI S-REFERENCE	AN OF CORRECTION SHOULD TO THE APPRICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 514	In review of the faci Medication Adminis Administrator on 1-2 revision date of 10-1 to verify physician indicated to check the separate times, whe the shelf or drawer, and when returning drawer.	age 11 ility policy entitled, "Oral stration," provided by the 24-11 at 12:15 a.m. with a 11-10, it indicated under step 1's orders. Under step 4, it the medication label 3 en taking the container from when pouring the medication the container to the shelf or ates to complaint number	F5	14						